

# Critical Incident Case Summaries

The OIG's Critical Incident case summaries are a description of the California Department of Corrections and Rehabilitation's (department) critical incident cases the OIG monitored and closed.

Filtered Cases: 1

## Incident Date

October 17, 2020

## Incident Type

Inmate Suicide

## Indicator

### Ratings\*

Indicators 1-3



Poor

\*Ratings subject to change

## OIG Incident Number

20-0035693-CI

## Incident Summary

On October 17, 2020, after an officer found an unresponsive incarcerated person in a cell, the officer, four other officers, a nurse, and two psychiatric technicians performed life saving measures, administered four doses of an opiate antidote, and transported the incarcerated person to the triage and treatment area where a paramedic pronounced him dead.

## Disposition

The coroner determined the cause of death was exsanguination of incised wound of upper left extremity and the manner of death was suicide. The department's Mortality Review Committee found the cause of death is exsanguination of incised wound of upper left extremity and the death was unexpected. The department's Suicide Review Committee determined that mental health clinicians improperly delayed the incarcerated person's referral to a higher level of care, failed to adequately document self harm incidents as required by policy, failed to provide proper risk ratings, and failed to follow procedure for referral to a mental health crisis bed. The Suicide Review Committee recommended the hiring authority provide appropriate training to clinicians, assess whether tracking and monitoring is needed for self harm incidents, audit and review five suicide risk assessments and self harm evaluations of the identified clinician, and review and audit ten mental health crisis bed referrals in the previous six months. In response, the hiring authority reviewed local operating procedures, completed audits, and provided training.

## Incident Rating

Overall, the department *poorly* handled the critical incident because based on the departments Suicide Review Committee's findings the mental health clinicians improperly delayed the incarcerated person's referral to a higher level of care, failed to adequately document self harm incidents, failed to provide proper risk ratings, and failed to follow procedure for referral to a mental health crisis bed.

Indicator 1: Did the department's actions prior to the critical incident sufficiently comply with policies, procedures, and best practices?

The department's performance prior to the critical incident was *poor* because based on the departments Suicide Review Committee's findings the mental health clinicians improperly delayed the incarcerated person's referral to a higher level of care, failed to adequately document self harm incidents, failed to provide proper risk ratings, and failed to follow procedure for referral to a mental health crisis bed.

### Questions

***Except for a deficiency noted in the answer to another question in this indicator, prior to the incident, did the department violate policy or procedure or not comply with best practice?***

The department mental health clinicians improperly delayed the incarcerated person's referral to higher level of care, failed to adequately document self harm incidents, failed to provide proper risk ratings, and failed to follow procedure for referral to mental health crisis bed.

Indicator 2: Did the department's actions during the critical incident sufficiently comply with policies, procedures, and best practices?

During the critical incident, the department performed in a *satisfactory* manner.

Indicator 3: Did the department's actions after the critical incident sufficiently comply with policies, procedures, and best practices?

After the critical incident, the department performed in a *satisfactory* manner.